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# Health Care: Meeting the Needs of the Nation's Poor

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# HEALTH CARE

*Meeting the Needs of  
the Nation's Poor*





By Louis W. Sullivan

**T**here is much misunderstanding about our health care system and the problems we face. Given the complexity of the health care system, the range of conflicting interests involved, and the diversity of views on health care reform, building consensus around a set of proposals will be very difficult.

Frankly, we seem to lack agreement even on some fundamental questions. For example:

What goals do we as a society have for our health care system; and are they reasonable?

What is the role of the patient, the provider, the insurer, taxpayer and other payers, and the government in health care?

What is the nature of the current system's problems?

Consensus is necessary before we can even begin to propose coherent solutions. The consequences of failing to achieve consensus were well demonstrated by the 1989 enactment and then repeal of the Medicare Catastrophic Care Coverage Act.

### The Charge

This is the third in a series of five national lectures on health policy reform. By way of background, President George Bush has asked me to lead a review of recommendations on the quality, accessibility and cost of our nation's health care system, and to suggest ideas for improvement.

In a speech last July to the Atlanta Business Roundtable, I laid out the principles which I believe must guide any improvement in our health care system. First and foremost, every American should have access to needed medical care. Furthermore, improvements should facilitate diversity of choice, encourage individual financial responsibility, expand access, and contain the growth in health care expenditures through better incentive structures and greater efficiency.

**The principal issue relating to health care for the poor is access. But much of the national discussion has focused . . . on solving the problem of the uninsured.**

Since July, I have given two more lectures, at Stanford University and at Yale University. The Stanford lecture concerned the high cost of care. Americans have spent more than \$650 billion or 12 percent of gross national product on health care in 1990. This compares with 5.3 percent in 1960, a bit more than 7 percent in 1970, and about 9 percent in 1980. The high cost of care is making access difficult for millions of our citizens. It is diverting resources from other important needs like housing, education and economic investment.

In the Stanford lecture I rejected federally funded national health insurance for several reasons: it would lead to government rationing of care; it would further escalate, not reduce, costs; and, as the United Kingdom and Canada have demonstrated, it would *not* cure the problems of access to care.

But I absolutely support universal access by building upon and preserving the current high quality of our system, while harnessing both the public and private sectors in a partnership to broaden access to care, especially for our low-income and minority citizens.

In my lecture at Yale, I talked about the importance of individual behavior, and about how the exercise of personal responsibility affects health and the cost of care. Many preventable illnesses and disabilities could be avoided through lifestyle changes and a deeper commitment to positive personal actions. I noted that healthy behavior protects good health, and can lead to empowerment, freedom and independence.

I also called for the creation of a culture of character, a climate encouraging healthy behavior in which friends, families, neighbors and communities work together to eliminate poor diets, the spread of drug use and AIDS, the abuse of alcohol, senseless violence and those other actions that undermine our health, freedom and dignity.

### Health Care and the Poor

I have chosen Howard University for my third national lecture because of the long-standing commitment this institution and many like it have to serving the health needs of America's disadvantaged. Also, to share my views with the community that is most committed to solving this problem.

The principal issue relating to health care for the poor is access. But much of the national discussion has focused too narrowly on solving the problem of the uninsured. While insurance is a necessary part of the discussion, it is too broad to allow for a cogent examination of the particular problems facing the poor. Insurance, I believe, is not an adequate barometer to access.

The current reexamination of the American health care system has come to be driven by, and dominated by, a symptom of our current difficulties, rather than by their underlying causes. The symptom, so frequently cited, is the 30 to 35 million Americans who lack health insurance. The number itself, 33 million for convenience, has been imbued with intrinsic substance and its own reality. But the mythology which has grown up around the number of



uninsured has diverted us from the fundamental problem—lack of access to health care.

Why do I say the number of uninsured is a symptom, a diversion? My claim is based on several reasons, having to do with both the composition of the uninsured and with the reference to "quick fix" proposals to overcome lack of insurance, rather than the real issue of access.

Let me be clear: Lack of financial access to health care is, too often, a problem. And I certainly believe that those without access, financial or otherwise, must have our help. Surely, as a compassionate and civilized society, we must be concerned when access to care is denied, and we must examine the causes.

But citing this 33 million figure is not useful because this number is too broad. It actually retards the effort to expand access. It misleads us to conclude that everyone who is uninsured does not have access to quality health care, or the reverse—that everyone who is insured does have that access. Simply, neither is true.

Let me dispel several myths:

□ The first myth is that **the uninsured and the poor are the same.**

The fact is that most of the uninsured, nearly three-quarters, are workers or their dependents. Why is this significant? Because employment-based health insurance is the dominant source of coverage for the under-65 population in this country. Employer plans cover two-thirds of Americans under 65, and nearly three-quarters of all workers. And, more significantly, because of tax subsidies, the effective cost to workers of employment-based coverage is roughly half the cost of equivalent coverage when paid for outside the workplace.

Thus, for low-income workers, absence of employment-based insurance is tantamount to being priced out of the insurance market.

A major problem is that, of the 33 million uninsured, most work in jobs in which insurance is not offered; by one estimate, 90 percent of uninsured workers are *not offered* health insurance by their employers. So the problem for most of the uninsured is *not* that they are poor, but that their employers do not offer health insurance, usually because the employers themselves cannot afford to do so.

But since roughly a third of the uninsured, mostly non-working, fall below the poverty line, they simply cannot afford insurance. For them, Medicaid and other

programs for the poor become their only option. And these programs, therefore, are left to provide their only health care, a safety net.

Another third have jobs and a cash income which, although steady and significant, is not substantial. Their earnings fall between 100 percent and 200 percent of the poverty line, and so many cannot afford insurance. For these so-called "working poor," the high cost forces them to choose between health insurance premiums and

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food; between the security of coverage at a later date and the immediate need to pay the heating bill.

For the final third without insurance, the issue is not necessarily poverty. Some may have pre-existing conditions which make them uninsurable. Most simply choose not to buy insurance. Some of these are persons willing to take a risk, who may feel indestructible, and who may decide to forego the expense of insurance.

While one may debate the wisdom of their choices, there are seven million uninsured with annual income above \$36,000 for a family of four. These are not persons who generally need or should be provided federally financed insurance. With few exceptions, they generally have financial access to care if they want it. Ultimately, they can afford health care when needed.

□ The second myth is that **the uninsured do not receive care.**

It is vital to remember that, insured or not, in any given year many of us have no need for medical intervention. For those who do, it is simply false that all the uninsured fail to get the services they need. In Medicare, for example, whose enrollees include the highest users of care—the elderly

and disabled—20 percent did not need even \$75 worth of Medicare physician services in 1990!

To be sure, when we need medical care we want it to be available. And for many of the uninsured in need of medical services, the range of their choices may be limited. But it is a matter of fact that where services are available, they are available to most people without insurance.

But it is important to be aware that Medicaid was not intended to provide health insurance for all the poor. By legislative design, it covers only those who are *both* income eligible and so-called "categorically" eligible: that is, the aged, blind, disabled, pregnant, those under 21 or in certain families with children who do not have parental support.

Those without insurance and not Medicaid-eligible, as hospitals like Howard University Hospital well know, show up as charity cases at community, non-profit hospital emergency rooms. They also use free or heavily discounted services at local public hospitals and health department clinics. They may go to federal, state or local programs, such as community or migrant health centers. In short, they receive charity care or their costs get rolled into unreimbursed provider "bad debt."

Because the present publicly supported system is a patchwork, a mosaic without a clear picture, order or form, the real problem, contrary to the myth that the uninsured do not receive care, is that the search for care is difficult, time consuming and too often embarrassing. The system available to those without other options is incoherent, undirected, fragmented, chaotic, and sometimes insufficient. There is little continuity of care, and virtually no emphasis on preventive services or follow-through. Consequently, too often, the poor delay treatment until it becomes absolutely necessary, and then treatment is more intrusive and more costly, and recovery is less satisfactory.

□ The third myth is that **insurance is sufficient to provide access for all Americans.**

The belief that putting an insurance card in every pocket will cure all our health care ills is false prophecy from those preaching easy solutions. But that perspective is erroneous because insurance alone does not and will not assure access. Some 85 percent of non-elderly Americans are covered by private insurance or a public health financing program. But that does not mean that





they have access to care. Insurance covers many health items. But it does not remove benefit limitations, lack of access to health care professionals in too many rural and inner city areas, socioeconomic barriers and many other constraints that are impeding access for many.

With regard to the deficiencies of government-sponsored health insurance, one need look no further than Medicaid. Consider programmatic limitations. Families of the "working poor" are ineligible for Medicaid coverage in many states, which explains why many of the uninsured are children. And because Medicaid is 50 different state-run programs, an important benefit covered in one state may not be covered in another. A reimbursement rate paid to providers in one state is likely to be different in another. As a result, many of those categorically eligible for Medicaid, even though poor, are not poor enough to be assured of securing covered access to needed services; similarly, providers are too often left without adequate payments, discouraging them from giving care.

These problems are not limited to Medicaid nor are they solely the product of state differences. Look, too, at private health insurance, whether employment-based or privately purchased. Benefits vary radically. While most policies contain a catastrophic limit on deductibles and co-payment requirements, many do not. While some policies are designed in such fashion as to cover cost-effective preventive services, many are not.

### Guiding Principles

If we are interested in clarity, we must instead outline some principles that should guide a more cogent examination of our national response to the needs of the poor.

The answer to improved access for the poor has to lie in federal, state and local programs targeted to the conditions and needs of the poor; in redefined priorities, favoring access and delivery; in consensus development and coalition building around the effective integration of services and management of care; and in a growing partnership among citizens, taxpayers, providers, and payers.

Recently, Emily Friedman wrote a provocative article, "To Save and Let Go," in *Health Management Quarterly*. She argued that we should not compromise what works in trying to fix what does not work. What is good in our system is the high quality of service and care available to those who have



access; the expanded and growing range of choices for consumers in both institutional and non-institutional settings; the willingness and ability of health care personnel to consistently function in a creative, hard working and effective manner; and of course, to preserve our technological leadership, which is helping providers offer more successful, less intrusive medical care.

Friedman concludes her analysis by noting that "Ours is not a perfect system, and if we pursue perfection, we could inadvertently sacrifice the good; yet somewhere in the balance between what we have done wrong and what we are doing right, we will find the future of health care."

Friedman's advice—the need to search for balance—is timely and constructive. We must use the strengths and initiative of both the public and the private sectors.

In the important "laboratory of the states," consensus and collaboration will emerge from goal-oriented dialogue among employers, health care providers, insurers, consumers, government and taxpayers. This consensus will lead to actions which reflect the particularities of regional circumstances requiring unique solutions. Hard decisions and compromises will be required from all.

Our FY 1992 federal budget proposals move in this direction. They do so in part by proposing to extend flexible resources to the states, in part by helping to fill current gaps, and in part by making a first move toward increased responsibility for the wealthy to pay their own way.

Under current law, all taxpayers subsidize physician services under Medicare. These subsidies amount to 75 cents on the dollar for *everyone* over age 65 who voluntarily enrolls in Part B of Medicare. Regardless of their individual circumstances and income, *anyone* enrolled pays only 25 cents for every dollar of Medicare premium. This seems neither sensible nor necessary, and certainly is not equitable to taxpayers.

We are proposing, therefore, that those Medicare beneficiaries whose adjusted gross incomes exceed \$125,000 for an individual and \$150,000 for a couple no longer be so greatly subsidized—that the subsidy be reduced from 75 percent to 25 percent. Those with very high incomes will have to pay more for Medicare. This is not unreasonable or unfair. More importantly, it frees more public resources for use where they are needed—for those who simply cannot pay for access to care.

As Congress considers our proposal to reduce tax-payer subsidies for physician services to very wealthy Medicare enrollees, the Medicare budget savings this proposal would secure could be used elsewhere, including Medicaid, to improve access to care. While the federal government can help and has a real role to play, the federal budget cannot do it all.

### Broadening Access

Let me again emphasize, that we must turn the debate to confront squarely the issue

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of access. We must work to broaden access, to make the health care system more open, affordable, coherent, and effective; and we must do it in innovative ways. All Americans must have access to high quality care, but it cannot be done simply by the federal government writing a check.

Rather, improved access requires the effort of every element of our society. Health care must be a persistent and pervasive priority for all Americans—our families and friends, medical professionals, community leaders, taxpayers, non-profit organization, the media and policy-makers. No one group can effectively meet the health care needs of our citizens.

We need to look to the proven creativity of state, regional and private sector leadership that is already evident, such as the primary care consortium of Dade County; the Central Alabama Perinatal Care System; the Seattle Obstetrical Care Project; the activities of the Robert Wood Johnson Foundation working with state, local and private groups; and the Council of Smaller Enterprises in Cleveland.

Certainly, lower costs are essential. That will require all of us—patients, physicians, nurses, hospital administrators, and policy-makers—to find ways to make the system more efficient without compromising its effectiveness. We all know that efforts to contain costs are needed. In Medicare, our

prospective payment system and physician payment reform efforts are steps in the right direction.

Our programs for the poor must be more coherent and more "user friendly." We know that we must reform and expand Medicaid and other programs so that the needs of the poor are met. Physicians, hospitals, philanthropic organizations, advocacy groups, state and local health officials and policy-makers all have a role. Each community has different needs, so programs must become, and remain, flexible.

This administration continues to try to meet this goal. For example, until reforms were enacted last year, only one in three poor women of childbearing age was covered by Medicaid, which was one reason for our nation's high infant mortality rate. However, we worked with the Congress to greatly expand Medicaid to cover all pregnant women and children up to age 6 in families with incomes up to 133 percent of the poverty level—opening coverage to over one million more women and children.

In addition, last year we devoted more than \$5 billion to infant and child health services and research. But we have determined that additional funds, specifically targeted to unique local needs, would save more of our babies. Therefore, in our FY 1992 budget request we have a new initiative to organize and develop community-oriented programs to reduce barriers to appropriate prenatal and perinatal care for pregnant women and infants in 10 areas. Over \$170 million will be directed in 1992 to these target areas.

We also must work to increase the number of health care professionals in underserved areas. I know that Howard medical alumni have an excellent record of service to the community. Many have sought the challenge of the inner city or economically-depressed rural areas. This is a trend we must maintain and encourage, urging our medical students and other health care professionals, many of whom are originally from these areas, to practice their healing arts where they are so desperately needed.

But I do not mean to suggest that new physicians from minority or rural communities can or should be expected to bear an unfair share. We need, as well, to maintain, through the medical education process, the enthusiasm and dedication which brought and continues to bring most students to medical school in the first place: the desire



to help; the desire to improve the condition of the sick, the poor, the elderly; the desire that the world should be a better place for our having passed through it.

The Department of Health and Human Services is working to end the paucity of health care personnel in underserved areas. Because of the high rate of service in these areas by minority health professionals, we have increased the availability of financial opportunities for disadvantaged students who are under-represented in the health care professions. Our 1992 budget request of \$157 million is an increase of more than 30 percent over the previous year.

This money will be used to expand the National Health Service Corps recruitment program and the Health Professions Student Loan program, and to establish a new federal construction program to enable minority health professions educational institutions to improve their research facilities.

Dollars alone will not overcome the problem of too few minority, rural and other health professionals. We can, and will increase educational grants, but it is the commitment of every local educational system where the encouragement, the mentoring, the leading by example, and the vision must emerge. And it is here, too, where we must work to end racial and ethnic barriers to access.

### Adequate Funding

Our 1992 budget request for minority health programs is \$682 million. In part, these programs are designed to increase awareness and outreach in the minority community. But until we make this a top priority in our minority communities—a personal and community priority for each and every man and woman, boy and girl—our low-income and minority citizens will continue to confront higher rates of cancer, heart disease, hypertension, stroke, HIV infection and many other preventable diseases.

We need to create, in minority as well as majority communities, a "culture of character," a climate of individual responsibility to encourage healthy behavior. The top 10 causes of premature death in our nation are significantly influenced by personal behavior and life style choices. More positive health behavior could eliminate up to 45 percent of deaths from cardiovascular disease, 23 percent of deaths from cancer and more than 50 percent of the disabling complications of diabetes.

Finally, I cannot come to Howard without

noting and acknowledging the difficulties faced by our minority hospitals. It is the case that health care institutions across this country, academic or otherwise, minority or majority, are laboring under extraordinary changes. Indeed, hospitals are not immune to the realities of the market-place. Minority hospitals, while they serve a special role in the community, are perhaps more vulnerable to the storm in the marketplace and the turbulence in the health care system, including cost inflation, facility inefficiencies, physician referral pat-

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terns, and the choices patients make among facilities.

Minority hospitals, such as the Howard University Hospital, continue to serve a special role in preserving the health of those in our minority communities. Yet, despite the special role they play in our communities, like all hospitals today, they must answer the hard questions themselves or the market will do it for them—questions such as:

- ☐ Whether to try to remain full-service, all-purpose institutions at a cost which becomes ever steeper; or,
- ☐ Instead, to rethink and redefine their long-standing mission, tailoring their services to meet new needs and accommodate new realities.

These options, business as usual with financial disaster as one possible result, or restructuring to serve very important but more limited roles as another, represent choices that will determine the existence of these old and well-served institutions and will affect the access of the poor and minorities to needed health care.

We are working to find ways to soften the impact and ease of the transition. But, re-funding, restructuring, and realignment are essential for the long run survival of our hospitals, and essential to the continued availability of health care services to minor-

ities and the poor.

### Conclusion

By categorizing all of the uninsured together, we have allowed an implicit, false premise to drive our policy discussions—that being uninsured, by its very nature, means a denial of access. This conceals a half-truth, that some without insurance also do not have access, and it fosters a subtle misperception that *all* without insurance are in the same boat. This mistake is repeated in discussions of health care reform, obscuring the true problem—access to health care for those who, through no fault of their own, cannot get it: the poor, the unemployed, and those who live in areas where care is not readily available.

All Americans should have needed health care. The road to reform must include providing effective access to an expanded system of public and private access: financial access and effective access. We must, together, overcome barriers of high costs, programmatic restrictions, inadequate medical personnel, inadequate resources and ethnic barriers; and as part of that effort, we must expand and improve the public/private primary care delivery system and strengthen the foundations of public health.

Financing is crucial; but, by itself, is not sufficient. Help from the federal government is important. But equally important are city, county, state and private collaborations and creativity. □

*Louis W. Sullivan, M.D., is secretary of the U.S. Department of Health and Human Services. The above was excerpted from a presentation at Howard University in February.*